Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 21, 2017	2017_646618_0011	020474-16, 023072-16, 007755-17, 007841-17	Complaint

Licensee/Titulaire de permis

ORILLIA LONG TERM CARE CENTRE INC.
689 YONGE STREET MIDLAND ON L4R 2E1

Long-Term Care Home/Foyer de soins de longue durée

LEACOCK CARE CENTRE
25 MUSEUM DRIVE ORILLIA ON L3V 7T9

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

CECILIA FULTON (618)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 24, 25, 26, 27, 28, May 2, 3, 4, 5, 8, 9, 11, 2017

The following complaint intakes were inspected during this inspection: Log #'s 023072-16, 007755-17, 020474-16, 033754-16 and 007431-17.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing (DOC), the Co- Director of Care (Co-DOC), registered nursing staff, personal support workers, residents and Substitute decision makers (SDMs).

During the course of the inspection, the inspector(s) observed residents and staff to resident interaction and the provision of resident care in the resident home areas, and reviewed resident health records, staff training records and home policies.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

This inspection was initiated to inspect items identified in an identified intake log relating to abuse from resident #001 towards resident #002.

Record review revealed that there had been an identified number of resident to resident abuse involving resident #001 and #002, and two other incidents where resident #001 was found in resident #002's room. Record review also revealed many incidents where resident #001 had exhibited identified responsive behaviours toward residents and staff.

On three identified occasions, resident #001 had exhibited and identified responsive behaviour toward resident #002. Two of the occasions resulted in injury to resident #002 and one occasion the resident required further assessment at the hospital.

Review of resident #001's clinical records and plan of care revealed that he/she had many responsive behaviors.

Interventions identified in resident #001's care plan included monitoring, and re-directing as well as the use of medications.

Review of resident #001's Medication Administration Record (MAR) revealed that he/she was not given the prescribed medications as ordered on many occasions.

Interviews with registered staff #102 and #103 revealed that if this resident was asleep during an identified medication pass he/she would not wake the resident up to administer his/her medications because of the resident's identified responsive behaviours.

Interview with registered staff #102 and #114 further revealed that neither staff were aware that this resident missed so many doses of the medications neither were they aware if the doctor was aware of this resident not receiving many of the prescribed medications.

Record review revealed that Dementia Observation System (DOS) monitoring had been initiated for this resident on several occasions and that DOS documentation was often not completed as required.

Specific to the identified reported incident between resident #001's and resident #002 which resulted in injury to resident #002, DOS monitoring had been initiated, however review of the DOS monitoring sheet revealed many missed times including the entire 24

hour during which this incident occurred.

Record review of progress notes revealed that a third party consultation had been done to review resident #001. An Initial Assessment report from the consultant team was found in the resident's chart. This assessment contained many recommendations including completing a COHEN Mansfield Agitation Inventory, implementing Antecedent, Behaviour, Consequence documentation, obtaining identified material interventions and using Stop and Go approach when providing care. Review of resident #001's written plan of care did not include any of the recommendations found in this report, and the only mention of this report in resident #001's plan of care is that the referral was accepted on an identified date in 2017.

Interview with Co-Director of Care, staff #112 revealed that they had not seen this report until the Inspector brought it to their attention. Staff #112 believed that there had been some issue of faxing or delivery of this report that led to it getting missed. Staff #112 confirmed that the recommendations identified in this report had not been included in the resident's plan of care.

Record review also revealed a subsequent note left by the consultant team stating that they would like to be notified if resident has any further identified responsive behaviours and provided two phone numbers to contact them at.

Review of the resident's plan of care reveals that this information is not included in the plan of care.

Interview with registered staff #107 and #124 revealed that they were not aware of this recommendation.

Interview with the consultant revealed that he/she had not received any calls about this resident's behaviours until two months later. The consultant further revealed that they did not know if the home was following any of their recommendations.

Record review did not identify any interventions which would have restricted or deterred resident #001 from entering resident #002's room and interview with resident #002's Substitute Decision Maker (SDM) revealed that no intervention had been in place.

Interview with staff #007 revealed that they had never observed an identified intervention in use.

Staff #118 stated additional monitoring of resident #001 was achieved by providing single care in that hallway which would allow staff to be more present. Staff #118 stated he/she was aware that resident #001 had a tendency to enter resident #002's room, and he/she recalled that they thought an intervention had been in place before the third incident.

Record review, staff interview, and interview with SDM revealed that strategies were offered to manage resident #001's responsive behaviours. They included medication management, monitoring, DOS monitoring, implementing the consultant's recommendations and reaching out to the consultant team and use of an identified intervention. However these strategies were not implemented as ordered and as a result of not managing resident #001's responsive behaviours, resident #002 was not protected from abuse.

The severity of the non-compliance and the severity of the harm were actual. The scope of the noncompliance was isolated. A review of the Compliance History revealed that there was a Written Notification (WN) and a Compliance Order (CO) issued in inspection #2016_333577_0008, dated October 3, 2016; and a WN and VPC issued in inspection #2016_334565_0004, dated March 10, 2016. As a result of the severity, scope, and the licensee's previous compliance history, a compliance order is warranted. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents

This inspection was initiated to inspect items identified in two Critical incident reports and one complaint relating to resident to resident abuse.

Record review revealed that between two identified months in an identified year dates in 2016, there were eight documented incidents of identified responsive behaviours exhibited toward staff by resident #001. In an identified five month time period there were three incidents of resident to resident abuse involving resident #001 and #002, and two other incidents where resident #001 was found in resident #002's room but no contact was identified. Record review also revealed many incidents where resident #001 had exhibited identified responsive behaviours.

Review of resident #001's clinical records and plan of care revealed that he/she had many responsive behaviors.

Interventions identified in resident #001's care plan included monitoring, and re-directing as well as the use of medications.

Review of resident #001's Medication Administration Record (MAR) revealed that he/she was not given the prescribed medications as ordered on many occasions.

Interviews with registered staff #102 and #114 revealed that if this resident was asleep on the identified medication pass they would not wake him/her up to administer medications because of his/her responsive behaviours.

Interview with registered staff #102 and #114 further revealed that neither staff were aware that resident missed many doses of the medications, neither were they aware if the doctor was aware of this resident not receiving many of the prescribed medications.

Record review revealed that DOS monitoring had been initiated for this resident on several occasions and that DOS documentation was often not completed as required.

Specific to the identified incident of the identified responsive behaviour, DOS monitoring had been initiated, however review of the DOS monitoring sheet revealed many missed times including the entire 24 hour period when the incident occurred.

Record review of progress notes revealed that a third party team had been consulted to assess resident #001. An Initial assessment report from the consult team, on an identified date, was found in the residents chart. This assessment contained many recommendations to manage responsive behaviours. Review of resident #001's written plan of care did not include any of the recommendations found in the consultant's report, and the only mention of this report in resident #001's plan of care was that the consultant referral was accepted on an identified date.

Interview with Co-Director of Care, staff #112 revealed that he/she had not seen this report until the Inspector brought it to his/her attention. Staff #112 believed that there had been some issue of faxing or delivery of this report that led to it getting missed. Staff #112 confirmed that the recommendations identified in this report had not been included in the resident's plan of care.

Record review also revealed a subsequent note left by the consultant team which stated that they would like to be notified if resident has any further identified responsive behaviours.

Review of the resident's plan of care revealed that this information was not included in the plan of care.

Interview with registered staff #107 and #124 revealed that they were not aware of this recommendation.

Interview with the consultant revealed that he/she had not received any calls about this resident's behaviours until an identified date. The consultant further revealed that he/she did not know if the home was following any of their recommendations.

Record review did not identify any interventions which would have managed resident #001's identified responsive behaviours. Interview with resident #002's Substitute Decision Maker (SDM) revealed that the identified interventions had not been implemented until after the third incident.

Interview with staff #007 revealed that they had never observed one of the identified interventions in use.

Staff #118 stated additional monitoring of resident #001 was achieved by providing single care in that hallway which would allow staff to be more present. Staff #118 stated he/she was aware that resident #001 had a tendency to enter resident #002's room, and he/she recalled that they thought an identified intervention was in use.

Record review, staff interview, and interview with SDM revealed that there were strategies offered to protect residents and staff who were at risk of harm as a result of resident #001's behaviours, however many of the identified strategies including medication management and monitoring, DOS monitoring, implementing the consultant's recommendations and reaching out to the consultant team and use of an identified intervention were not implemented and as a result residents and staff continued to be at risk of harm from this resident's responsive behaviour.

The severity of the non-compliance and the severity of the harm were actual. The scope of the noncompliance was isolated. A review of the Compliance History revealed a previous WN and VPC in a similar area in inspection #2015_168202_0016, dated September 15, 2015. As a result of the severity and scope and the compliance history a compliance order is warranted. [s. 54. (a)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

On an identified date a complaint had been received by the Ministry of Health and Long-Term care (MOHLTC) related to care concerns identified for resident #003.

The written plan of care for this resident stated that resident #003 had an identified bathing preference.

Interview with resident #003 revealed that he/she always received an identified bathing procedure.

Interview with Registered staff #129 and PSW #130 revealed that resident #003 has always received the identified bathing procedure since his/her admission.

Staff #129 and #130 both confirmed that the information in resident #003's written plan of care was not correct and did not provide clear direction with regards to resident #003's bathing preference [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

This inspection was initiated to inspect items identified in a complaint made to the Ministry on an identified date related to the provision of care.

The complaint stated that resident #004's plan of care had not been followed with regards to positioning of the resident and this has resulted in the resident experiencing identified medical consequences.

Record review revealed that on an identified shift and date, resident #004 was discovered to be in an identified position when in bed.

Interview with registered staff #107 revealed that on an identified date, he/she had been called by a PSW to assess the resident who had been discovered in bed, with the bed in an identified position. Registered staff #107 revealed that when he/she arrived the resident's health appeared to have declined in and identified manner.

During the course of this inspection on an identified date and time, Inspector #618 observed the resident to be in bed in an identified position and condition. The inspector called registered staff #120, who confirmed that the resident was in an identified condition.

Review of the current plan of care revealed that resident was to have the bed positioned a specified way for long periods of time due to it resulting in an identified difficulty. Further, he/she was to be positioned in an identified manner in order to maintain positioning. The plan of care did not contain any information regarding the other therapy.

Observation and staff interview confirmed that the delivery of care for the resident was not consistent with the directions set out in the plan of care for this resident. [s. 6. (7)]

3. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

A review of resident #001's clinical records identified the resident to have responsive behaviours. The plan of care for the resident directed staff to monitor the resident using

the Dementia Observation System (DOS).

Interview with registered staff #111 revealed that DOS monitoring can be initiated by any staff member as a method of monitoring a resident's behaviour. He/she revealed that once initiated, the DOS monitoring should be documented for the identified time period and that the task of performing the DOS monitoring usually falls to the PSWs, however any staff can perform this monitoring task.

Interview with registered staff #107 revealed that the DOS clipboard is usually left at the desk and that once initiated DOS monitoring continues for five days or longer depending on the nature of the behaviours.

Review of progress notes and DOS monitoring records for resident #001 revealed that on an identified month, a nurse manager called and told staff to place resident #001 on DOS monitoring. Progress notes document that DOS monitoring continued for two days, and then there was no further documentation regarding the continuation or stopping of the DOS monitoring in progress notes.

Review of the progress notes revealed a progress note on a subsequent identified month, indicating that DOS had started. A note written four days later stated DOS continues. A physician note of an identified month, stated, re-assess DOS charting when complete. There was no further documentation regarding this DOS monitoring. Review of the every 15 minute DOS Monitoring sheet showed monitoring documented on an identified month and that it stopped one day later.

Review of progress notes for a further subsequent month, revealed many statements regarding resident remaining on DOS observation, including a physician note. Review of the corresponding DOS monitoring to the progress notes reveal many gaps in the documentation of the DOS monitoring.

Review of the DOS monitoring records and corresponding progress notes with the Director of Nursing (DON), staff #116 reveal that the documentation was not complete for this intervention. [s. 6. (9) 1.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with.

Review of the home's medication policy, titled Residents Rights, Care and Services,- Medication Management – Administration of Medications, dated October 21, 2013 was conducted as part of this inspection.

The policy stated that registered staff are to ensure that a medication order is complete and legible and includes; Date and time of order, Resident's name, Name of medication to be administered, Dosage of medication to be administered, Route of medication to be administered, Frequency in which the medication is to be administered and signature and status of the prescriber.

The policy also stated that staff are to clarify any incomplete, inappropriate and or misunderstood orders.

Review of resident #004's chart revealed a progress note of an identified month, with a notation provided by a therapist summarizing his/her assessment and recommendations for the resident's therapy. Below the typed progress note was a hand written note that presumably written by the physician although the signature was not legible.

In a subsequent month, registered staff #107 transcribed this faxed order onto a physician order page and identified it as a fax order from Physician #142.

Review of this order with registered staff #107 and #124 revealed that both staff identified this order as incomplete and that neither of these staff members had sought to clarify the order with the prescriber.

Review of the order with the DOC revealed that the registered nursing staff should have confirmed the order for resident #004 with the prescriber when it was identified as incomplete. [s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice.

A complaint was received on an identified date related to the provision of care for resident #003.

In the course of the inspection, other residents were interviewed to seek information of staff to resident interactions and activities around transporting residents to and from the bath/shower room.

Resident #007 was one of these resident's who was interviewed and during the course of speaking with this resident, he/she revealed that he/she is only offered a an identified bathing measure once a week despite having identified this as their preferred choice for bathing.

The resident stated that he/she has made it very clear to staff that he/she does not want the alternative method of bathing and prefers to have the same preference twice per week.

The resident's written plan of care states that resident prefers shower or bath with no preference. Offer both.

The resident states that he/she is only offered an identified bathing method on his/her scheduled bath day, but not when the bathing is scheduled on the evening shift.

Interview with staff #140 revealed that they are aware of this resident's preference but often only offer the alternative.

Interview with the DOC confirm that if a resident has identified a preference, they should be offered that option and that the plan of care should identify this preference clearly.

The DOC confirmed that not offering the residents preferred choice in bathing does not respect the resident's choice. [s. 33. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

A complaint intake was received by the Ministry of Health (MOH) on an identified month in 2017 regarding management of responsive behaviours in the home.

Review of resident #001 Medical Administration Record (MAR) for an identified time period, revealed that the resident was prescribed a number of medications for treatment of their identified diagnosis, which had not been not administered according to the direction of the prescriber.

The reason documented on the E-MAR for not administering the above medications as prescribed was because the resident was asleep at the time of the medication pass or the resident refused the medication.

Review of the E-Mar with registered staff #103 revealed that he/she was a signatory to many of the missed medication doses. Interview with staff #103 revealed that he/she would make the decision to wake a sleeping resident up on a resident by resident basis and further revealed that he/she would not wake this resident up to administer medications because of the residents responsive behaviours.

Review of the E-Mar with registered staff #102 revealed that she was a signatory to many of the missed medication doses. Interview with staff #102 revealed that if a resident is sleeping he/she would not wake them up to administer medications.

Both registered staff #102 and #103 confirmed that the medications were not administered to resident #001 on the occasions documented on the E-MAR. [s. 131. (1)]

Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d’inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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Issued on this 12th day of July, 2017

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CECILIA FULTON (618)
Inspection No. / No de l'inspection :	2017_646618_0011
Log No. / Registre no:	020474-16, 023072-16, 007755-17, 007841-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 21, 2017
Licensee / Titulaire de permis :	ORILLIA LONG TERM CARE CENTRE INC. 689 YONGE STREET, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	LEACOCK CARE CENTRE 25 MUSEUM DRIVE, ORILLIA, ON, L3V-7T9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tracy Muchmaker

To ORILLIA LONG TERM CARE CENTRE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

Upon receipt of this order the licensee shall:

Prepare, submit and implement a plan that includes the following requirements and the person responsible for completing the tasks:

a. Provide education and training to all staff in the home on the importance of identifying residents at risk by co-residents who exhibit identified responsive behaviours.
b. Where identified behaviours have been identified, that the plan of care clearly identifies what strategies are in place to protect residents at risk of abuse from residents who exhibit the identified responsive behaviour.
c. the importance of ensuring that tools and strategies to protect residents from co-residents who exhibit the identified responsive behaviour are fully implemented and documented.

The plan is to be submitted to Cecilia.fulton@ontario.ca by July 10, 2017 and implemented by September 29, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

This inspection was initiated to inspect items identified in an identified intake log relating to abuse from resident #001 towards resident #002.

Record review revealed that there had been an identified number of resident to resident abuse involving resident #001 and #002, and two other incidents where

resident #001 was found in resident #002's room. Record review also revealed many incidents where resident #001 had exhibited identified responsive behaviours toward residents and staff.

On three identified occasions, resident #001 had exhibited and identified responsive behaviour toward resident #002. Two of the occasions resulted in injury to resident #002 and one occasion the resident required further assessment at the hospital.

Review of resident #001's clinical records and plan of care revealed that he/she had many responsive behaviors.

Interventions identified in resident #001's care plan included monitoring, and re-directing as well as the use of medications.

Review of resident #001's Medication Administration Record (MAR) revealed that he/she was not given the prescribed medications as ordered on many occasions.

Interviews with registered staff #102 and #103 revealed that if this resident was asleep during an identified medication pass he/she would not wake the resident up to administer his/her medications because of the resident's identified responsive behaviours.

Interview with registered staff #102 and #114 further revealed that neither staff were aware that this resident missed so many doses of the medications neither were they aware if the doctor was aware of this resident not receiving many of the prescribed medications.

Record review revealed that Dementia Observation System (DOS) monitoring had been initiated for this resident on several occasions and that DOS documentation was often not completed as required.

Specific to the identified reported incident between resident #001's and resident #002 which resulted in injury to resident #002, DOS monitoring had been initiated, however review of the DOS monitoring sheet revealed many missed times including the entire 24 hour during which this incident occurred.

Record review of progress notes revealed that a third party consultation had

been done to review resident #001. An Initial Assessment report from the consultant team was found in the resident's chart. This assessment contained many recommendations including completing a COHEN Mansfield Agitation Inventory, implementing Antecedent, Behaviour, Consequence documentation, obtaining identified material interventions and using Stop and Go approach when providing care. Review of resident #001's written plan of care did not include any of the recommendations found in this report, and the only mention of this report in resident #001's plan of care is that the referral was accepted on an identified date in 2017.

Interview with Co-Director of Care, staff #112 revealed that they had not seen this report until the Inspector brought it to their attention. Staff #112 believed that there had been some issue of faxing or delivery of this report that led to it getting missed. Staff #112 confirmed that the recommendations identified in this report had not been included in the resident's plan of care.

Record review also revealed a subsequent note left by the consultant team stating that they would like to be notified if resident has any further identified responsive behaviours and provided two phone numbers to contact them at.

Review of the resident's plan of care reveals that this information is not included in the plan of care.

Interview with registered staff #107 and #124 revealed that they were not aware of this recommendation.

Interview with the consultant revealed that he/she had not received any calls about this resident's behaviours until two months later. The consultant further revealed that they did not know if the home was following any of their recommendations.

Record review did not identify any interventions which would have restricted or deterred resident #001 from entering resident #002's room and interview with resident #002's Substitute Decision Maker (SDM) revealed that no intervention had been in place.

Interview with staff #007 revealed that they had never observed an identified intervention in use.

Staff #118 stated additional monitoring of resident #001 was achieved by providing single care in that hallway which would allow staff to be more present. Staff #118 stated he/she was aware that resident #001 had a tendency to enter resident #002's room, and he/she recalled that they thought an intervention had been in place before the third incident.

Record review, staff interview, and interview with SDM revealed that strategies were offered to manage resident #001's responsive behaviours. They included medication management, monitoring, DOS monitoring, implementing the consultant's recommendations and reaching out to the consultant team and use of an identified intervention. However these strategies were not implemented as ordered and as a result of not managing resident #001's responsive behaviours, resident #002 was not protected from abuse.

The severity of the non-compliance and the severity of the harm were actual. The scope of the noncompliance was isolated. A review of the Compliance History revealed that there was a Written Notification (WN) and a Compliance Order (CO) issued in inspection #2016_333577_0008, dated October 3, 2016; and a WN and VPC issued in inspection #2016_334565_0004, dated March 10, 2016. As a result of the severity, scope, and the licensee's previous compliance history, a compliance order is warranted. [s. 19. (1)] (618)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 29, 2017

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee shall:
1. Within twenty days of receipt of this order the home will convene a meeting with registered staff to review the responsive behavior program with particular focus on:
a. the importance of medication in managing responsive behaviours and the importance of monitoring the effectiveness of medications
b. Where the identified responsive behaviour has been identified that the plan of care clearly identifies interventions.
c. Review and implementation of third party recommendations focusing in on communication of the third party recommendations and implementation of recommended strategies.
d. The roles and responsibilities of all staff around DOS monitoring as a tool to evaluate and instruct the development of further care planning.

2. As part of the home's responsive behaviour program the home will develop a process to monitor compliance with medication administration particularly as it applies to capturing resident's response to medications and impact of not receiving prescribed medications.

3. As part of the home's responsive behaviour program the home will develop clear direction on how third party recommendations will be received, communicated, reviewed, implemented and evaluated.

4. As part of the homes responsive behavior program the home will develop a process to monitor compliance with use of developed interventions used by the home to manage the risks associated with wandering behaviour.

Grounds / Motifs :

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents

This inspection was initiated to inspect items identified in two Critical incident reports and one complaint relating to resident to resident abuse.

Record review revealed that between two identified months in an identified year dates in 2016, there were eight documented incidents of identified responsive

behaviours exhibited toward staff by resident #001. In an identified five month time period there were three incidents of resident to resident abuse involving resident #001 and #002, and two other incidents where resident #001 was found in resident #002's room but no contact was identified. Record review also revealed many incidents where resident #001 had exhibited identified responsive behaviours.

Review of resident #001's clinical records and plan of care revealed that he/she had many responsive behaviors.

Interventions identified in resident #001's care plan included monitoring, and re-directing as well as the use of medications.

Review of resident #001's Medication Administration Record (MAR) revealed that he/she was not given the prescribed medications as ordered on many occasions.

Interviews with registered staff #102 and #114 revealed that if this resident was asleep on the identified medication pass they would not wake him/her up to administer medications because of his/her responsive behaviours.

Interview with registered staff #102 and #114 further revealed that neither staff were aware that resident missed many doses of the medications, neither were they aware if the doctor was aware of this resident not receiving many of the prescribed medications.

Record review revealed that DOS monitoring had been initiated for this resident on several occasions and that DOS documentation was often not completed as required.

Specific to the identified incident of the identified responsive behaviour, DOS monitoring had been initiated, however review of the DOS monitoring sheet revealed many missed times including the entire 24 hour period when the incident occurred.

Record review of progress notes revealed that a third party team had been consulted to assess resident #001. An Initial assessment report from the consult team, on an identified date, was found in the residents chart. This assessment contained many recommendations to manage responsive

behaviours. Review of resident #001's written plan of care did not include any of the recommendations found in the consultant's report, and the only mention of this report in resident #001's plan of care was that the consultant referral was accepted on an identified date.

Interview with Co-Director of Care, staff #112 revealed that he/she had not seen this report until the Inspector brought it to his/her attention. Staff #112 believed that there had been some issue of faxing or delivery of this report that led to it getting missed. Staff #112 confirmed that the recommendations identified in this report had not been included in the resident's plan of care.

Record review also revealed a subsequent note left by the consultant team which stated that they would like to be notified if resident has any further identified responsive behaviours.

Review of the resident's plan of care revealed that this information was not included in the plan of care.

Interview with registered staff #107 and #124 revealed that they were not aware of this recommendation.

Interview with the consultant revealed that he/she had not received any calls about this resident's behaviours until an identified date. The consultant further revealed that he/she did not know if the home was following any of their recommendations.

Record review did not identify any interventions which would have managed resident #001's identified responsive behaviours. Interview with resident #002's Substitute Decision Maker (SDM) revealed that the identified interventions had not been implemented until after the third incident.

Interview with staff #007 revealed that they had never observed one of the identified interventions in use.

Staff #118 stated additional monitoring of resident #001 was achieved by providing single care in that hallway which would allow staff to be more present. Staff #118 stated he/she was aware that resident #001 had a tendency to enter resident #002's room, and he/she recalled that they thought an identified intervention was in use.

Record review, staff interview, and interview with SDM revealed that there were strategies offered to protect residents and staff who were at risk of harm as a result of resident #001's behaviours, however many of the identified strategies including medication management and monitoring, DOS monitoring, implementing the consultant's recommendations and reaching out to the consultant team and use of an identified intervention were not implemented and as a result residents and staff continued to be at risk of harm from this resident's responsive behaviour.

The severity of the non-compliance and the severity of the harm were actual. The scope of the noncompliance was isolated. A review of the Compliance History revealed a previous WN and VPC in a similar area in inspection #2015_168202_0016, dated September 15, 2015. As a result of the severity and scope and the compliance history a compliance order is warranted. [s. 54. (a)] (618)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 29, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 21st day of June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cecilia Fulton

Service Area Office /
Bureau régional de services : Toronto Service Area Office